Tobacco Use and Treatment for Smokers with Mental Health Diagnoses

Webinar Q&A with Dr. Marc Steinberg

Did you miss the Tobacco Use and Treatment for Smokers with Mental Health Diagnoses webinar? You can stream it on SAMHSA's YouTube page to learn more about this topic.

I am surprised that there are seven medications for smoking cessation. What are they?
I suspect the confusion is over the term "medications" because we often only think of pills (and not NRT) as "medications." The seven FDA approved smoking cessation medications include varenicline, bupropion, nicotine patch, nicotine gum, nicotine lozenge, nicotine nasal spray, and nicotine inhaler. The patch, gum, and lozenge are available over-the-counter without a prescription.

I am currently a CASAC in New York State. Are there other webinars or trainings I can take to become a cessation specialist?
The most comprehensive listing is probably on the Association for the Treatment of Tobacco Use and Dependence (ATTUD) website, but the ones that are close to you are at Rutgers (full disclosure: I'm involved in both Rutgers trainings). There is a 5-day Certified Tobacco Treatment Specialist training and a 2-day Treating Tobacco Dependence in Behavioral Health training.

How did you assess the clinicians' fidelity to Motivational Interviewing?
We used the Motivational Interviewing Treatment Integrity coding system (MITI). The MITI is a behavioral coding system designed to measure MI competence. It is the most widely used MI fidelity instrument and has demonstrated validity and reliability in addition to sensitivity to changes in clinician behaviors. Two independent raters used the MI Treatment Integrity Code to rate audio recorded therapy sessions on 11 dimensions to ensure that the interventions were easily distinguishable from one another and to assess the skill with which MI was delivered. You can access my article online.

Did the presenter say that an ingredient in cigarettes affects the metabolism rate of mental health medications, or of medications to help people quit smoking?
Not smoking cessation medications. It affects the metabolism rates of some medications used to treat mental health symptoms (or really any medication that is metabolized via the cytochrome P450 system).

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Are psychiatrists, psychologists, or therapists being trained to help patients quit smoking?
Probably not at high enough rates. Locally, we have made sure that psychiatry residents learn about tobacco dependence treatment, but it is certainly not universal in medical school or Clinical Psychology Ph.D. programs. We also provide a two-day training on Treating Tobacco Dependence in Behavioral Health that many physicians and psychologists (along with other healthcare practitioners) attend.

How long are Dr. Steinberg's consultations with patients per session?
The consultations described in the webinar regarding the motivational interviewing studies were 45-minutes long.

How do you, Dr. Steinberg, think websites or smartphone apps designed to help people quit smoking fit into the treatment process for individuals with mental illness?
There is great promise for technology to bring treatment to the smoker instead of bringing the smoker to the treatment. There is some great research coming out of Dartmouth right now looking into this, but my sense of the literature is that it is too early to tell for this population. Of note, in addition to the great work out of Dartmouth, there are also plenty of not-so-great apps and websites out there, so be careful of the source and teach your patients that if it looks too good to be true, then it probably is!

Are there suggestions for garnering funding to address smoking cessation among individuals with mental illness on funding assistance?
My advice is to be persistent! My work has primarily been funded by the National Institute on Drug Abuse (NIDA) to do research. In New Jersey, we once had state funding to provide face-to-face treatment for tobacco dependence, but that is long gone. Finding clinical funding is very difficult, but not impossible.

Are there suggestions for building this into school curricula? Into substance abuse courses?
I don't have any experience working with school aged smokers, but it should fit seamlessly in substance abuse treatment programs. The staff are often a bigger barrier than the clients, so getting the staff on board is very important.

Does the presenter have any thoughts about working with more intensive clients such as on ACT teams?
I have not worked specifically with ACT teams, but have worked with outpatients with schizophrenia. A large proportion of the patients really do want to quit and we should provide them with the resources necessary to be successful.

If NRT is available, such as the patch how long should they be on it (2 months, 4 months, or as long as it takes)?
The package insert for the patch says to use it for 10 weeks. Clinically, I know many people who recommend using it longer and there does not appear to be any scientific reason to not use it for as long as it takes. Because "as long as it takes" is an "off label" indication, many are uncomfortable with this, however.

Any advice on how to respond to people who are already sick (for example, with lung cancer or COPD) who feel it's too late to quit smoking, that it won't change things?
I would use motivational interviewing and discuss quality of life issues. With COPD in particular, smokers are likely to recognize that as difficult as it is to breathe now, they are unlikely to want for it to be even harder to breath.

Do you have any guidelines or suggestions for working with dual diagnosis patients? Specifically, offering cessation to patients with mental health diagnoses and also undergoing detox for substance use?
I would not treat smokers with mental health diagnoses much differently depending on whether or not they had a comorbid substance use disorder. The main difference might be to incorporate skills they have already learned to address their drug of choice into tobacco dependence treatment. I would also point out the ways in which cigarette smoking can serve as a trigger to using their drug of choice, thus arguing that smoking can be a threat to their sobriety.

How can managers address the smoking of the behavioral health professionals they supervise?
I would make sure to not be punitive, but where possible, to offer opportunities for staff to seek tobacco dependence treatment (e.g., use some work time to call QuitLine), and if possible to provide free NRT or at least make sure HR negotiates for generous coverage of the prescription-only options for quitting smoking. Smoke-free grounds policies which make smoking less desirable tends to give smokers an additional reason to want to quit and may result in more quit attempts among clients and staff. At minimum, it should be clear to staff that they are not to smoke with their patients under the guise of building a therapeutic alliance.

There is often a significant history of adverse childhood events for the folks who use tobacco and have a mental health diagnosis. Is there any consideration of trauma and the fact that tobacco may be that person's solution when seeking to support/guide?
I think it is true that many smokers use cigarettes as a way to cope with a variety of issues. I believe that it is our job to teach more adaptive coping skills, however. We would never suggest that someone with an alcohol use disorder who drinks to cope, should continue to drink because they find it helpful in dealing with their anxiety, yet many take this approach to tobacco.

On the thank you slide, what does "TA" stands for?
TA stands for “Technical Assistance.” To learn more, visit the Program to Achieve Wellness website.

Do you know what percentage of drug rehabilitation facilities allow smoking? Do these facilities hire employees that smoke?
I’m afraid I don’t know the answer to this, but my sense is that many of the employees do smoke. I think it is important that the employees not smoke with the clients and not smell like smoke during the work day. It is also important, however, that the counselors not feel that they cannot advise their clients to quit smoking just because they may be smokers themselves.

Thank you for your presentation. Can you please comment on addressing behavioral health professionals who use tobacco products, which creates a whole host of issues in helping their patients quit. Thanks.
Two previous attendees beat you to this question (it's a good one!). Please see answers above.

Thank you so much for a very informative presentation! Comment: The utilization of peer supporters who have successfully quit may be helpful also.
Thanks for the kind words! I fully agree with you about peer support. My colleagues at the CHOICES program (njchoice.org) do great work and if you are not already familiar with them, I encourage you to look them up online.

I work with youth here in NM, we really focus working on motivation interviewing but difficult with this population when it comes to their addictions. Any pointers or information geared for youth?
New Mexico is certainly the place to get expertise in motivational interviewing! I don't have much experience working with youth, but my sense is that they are rather responsive to interventions consistent with the underlying perspective of MI. Youth may not feel accustomed to being on the receiving end of adults working to partner with them or respecting their autonomy, and so they are often impressed by that.

What is pharmacology proving to help people quit and stay quit, assessed at 1 year? Overall population and behavior health population?
All pharmacology studies include at least brief behavioral interventions in addition to the pharmacotherapy, so we cannot really determine quit rates of pharmacotherapy alone. The important thing, however, is that pharmacotherapy + behavioral treatment approximately doubles the effect of placebo + behavioral treatment. The bottom line is that pharmacotherapy and counseling each provide significant added value to the other and smokers should be provided with both.

How could we best approach practitioners that don't value cessation treatment in populations living with mental illness? Is there a way to frame or promote it?
I think providing objective data is often the best approach, but making emotional appeals are also important for some who ask questions such as, "How else are they going to cope?" People who say this are well-meaning and want to protect clients' ability to soothe themselves. I would appeal to their concern by agreeing that we want our clients to feel calm and avoid anxiety, but that I want them to have *healthy* coping skills. We would never dismiss the importance of cessation in smokers without mental illness, so why should we for smokers who are even more vulnerable. Smokers with mental illness want to quit smoking and *can* quit smoking. We need to protect this vulnerable population and make sure they receive the treatment they deserve.

More needs to be said and understood that this will take many attempts for most people; that needs to be normalized.
I agree! This is true of all substance use disorders, and many non-substance use disorders as well. No one would say, "Well, you've tried to control your blood sugar before, so I'm just not going to bother addressing your diabetes anymore.